

How to complete your OMSIP Application Form for obtaining an OMSIP Contract

Please read the following instructions carefully before filling in your application card.
Samples of both the front and reverse sides of the application form are illustrated.

The numbers circled in blue on each sample correspond with the numbered instructions listed below.

1 Social Insurance Number. If you have a Social Insurance Number print it in the space provided.

2 Previous OMSIP coverage. If you have been insured before under an OMSIP contract, print the contract number and the last name of the contract holder in the space provided. If you do not know the previous contract number, print in "NOT KNOWN".

3 Last Name. Print your last or family name where indicated. (Example: Smith, Brown, Jones, etc.)

4 Given Names. Print your first given name (Example: John, Harry, Mary, Louise) on the line of squares headed "First Given Name". If you have a second given name place the initial of this name (Example: B for Betty or A for Adam, etc.) in the square headed "2nd Init."

5 Birthdate. Place the number of the day on which you were born, the month in which you were born (or its abbreviation) and the year in which you were born, in the space provided. (Example: 17 Feb. 1934).

6 Sex. In the box headed "Sex" indicate whether male or female.

7 Address. Print your address beginning with the house number and street and followed by the City, Town, Village or Post Office No., in the three lines of squares provided.

(Example: "123 Main Street, Toronto 7, Ontario" or "R.R. # 1 Kenora.")

8 County or District. In the box stating: "County or District", place the appropriate answer. For example, if you live in Peel County, print the word "Peel"; if you live in the District of Tamiskaming, print "Tamiskaming".

9 OHSC Number. If you are covered for hospitalization by the Ontario Hospital Services Commission (OHSC) please print your OHSC contract number in the squares provided.

10 Marital Status. Indicate which status applies to you by checking the appropriate box.

11 Occupation. Print in your occupation and the kind of business or industry in which you work (Example: Carpenter-Building; Farmer-Agriculture; Salesman-Bakery).

12 Dependents. Print the first name of your wife or husband on the line provided. Print the first name of each of your eligible dependant children, starting with the eldest, on the lines following. If you have more than four eligible dependant children, continue your list under the section headed: "Additional Dependant Children" located on the reverse side of the application. If you have more than nine eligible dependant children and you have filled out both related areas on the application form, list all others, in the same manner as on the application, on a

ONTARIO MEDICAL SERVICES INSURANCE PLAN APPLICATION FORM		FOR OFFICIAL USE ONLY	
P.O. BOX 1700, TERMINAL "A", TORONTO TELEPHONE: 365-5911 - 365-5951			
1 SOCIAL INSURANCE NUMBER 1 2 3 4 5 6 7 8 9		2 IF YOU HAVE BEEN COVERED BEFORE UNDER AN OMSIP CONTRACT EITHER AS A DEPENDANT OR CONTRACT HOLDER, INSERT PREVIOUS CONTRACT NUMBER AND LAST NAME OF PREVIOUS HOLDER	
3 YOUR LAST OR FAMILY NAME (SIGN ON BACK OF THIS FORM) DOE		4 FIRST GIVEN NAME JOHN	
5 BIRTH DATE 21 FEB 1936		6 SEX M	
7 YOUR ADDRESS 123 MAIN STREET YOURTOWN ONTARIO		8 COUNTY OR DISTRICT PEEL	
9 O.H.S.C. NUMBER 47751847		10 OCCUPATION AND NATURE OF BUSINESS OR INDUSTRY SALES-ADVERTISING	
11 DEPENDANTS (LIST ALL THOSE TO BE COVERED BY OR THROUGH YOU AND ALL CHILDREN INCLUDED MUST BE UNDER 18 YEARS OF AGE UNLESS OTHERWISE SPECIFIED AND MUST EMPLOYED IN-OWNERSHIP OR EMPLOYED BY SEPARATE COVERAGE) WIFE/HUSBAND: BETTY 12 JAN 31 F 1ST GIVEN NAME ONLY: FRANK 2ND CHILD: CAROLE 12 MAR 64 F 3RD CHILD: JANE 16 SEPT 58 F		PLEASE TURN OVER FOR SIGNATURE AND ADDITIONAL DEPENDANT CHILDREN	
FOR OFFICE USE ONLY M.C. (S.T.) A.D.A. BILL R.T. BILL (S.T.C.) EFFECTIVE DATE		STATION NO. DATE RECEIVED	

FRONT SIDE OF SAMPLE APPLICATION FORM

separate sheet and return this sheet with your application form to OMSIP.

In the section headed "Birthdate" print the number of the day of birth, the month and the year in which the child was born (Example: 19 Sept., 1954). In the section headed "Sex" indicate M for male and F for female.

13 New Residents. If you are a new resident of Ontario, in the box located under the statement: "If you have lived in Ontario for at least 90 days but for less than 120 days, state the date when you commenced residence," place the date (day, month, year) when you commenced living in Ontario. (New immigrants to Canada and Ontario qualify 90 days following the day of establishing landed immigrant status). If you apply for OMSIP coverage within the 30 day period following completion of your 90 day residency requirement, coverage commences on the first day of the month following that in which your application is received and approved at OMSIP.

14 Previous Coverage. If any of the dependants listed on the application, either the husband or wife, or dependant children, were covered under a previous OMSIP contract, print their first names, the last or family name, and the OMSIP contract number under which they were previously insured, in the space provided. If you do not know the previous OMSIP contract number, fill in dependant name(s), print "NOT KNOWN" in previous contract number box.

15 Leaving a Group Plan. If you are applying within 30 days of the termination of your coverage by a group medical insurance plan, print the date on which your coverage ended, the name of the insuring agency under which you were covered, and your former policy or contract number, on the appropriate lines in the box provided. You must also include a "notice of termination of group coverage" form #E239, available from OMSIP. Coverage with OMSIP then begins on the day following the date of termination of your group medical insurance coverage, providing you with continuous coverage.

ARIO FOR AT LEAST 90 DAYS,
BUT LESS THAN 120 DAYS,
STATE THE DATE WHEN YOU
COMMENCED RESIDENCE.

IF ANY OF THE LISTED DEPENDANTS WERE COVERED UNDER A
PREVIOUS OMSIP CONTRACT, GIVE THE LAST OR FAMILY NAME AND
THE CONTRACT NUMBER UNDER WHICH THEY WERE INSURED.

FIRST NAME

BETTY
DOUGLAS

LAST NAME

DOE

NUMBER OF PREVIOUS CONTRACT

1 2 3 4 5 6 7 8 9 0

GROUP INSURANCE PLAN WITH-
IN THE LAST 30 DAYS STATE

DATE OF TERMINATION:

NAME OF INSURING AGENCY:

POLICY OR CONTRACT NO.:

IN APPLYING FOR COVERAGE UNDER THE MEDICAL SERVICES
INSURANCE ACT 1965, I CONFIRM THAT I AM NOT COVERED
FOR TOTAL MEDICAL CARE BY GOVERNMENT AND THAT THE
INFORMATION GIVEN BY ME IS CORRECT.

16

24 MAY 67

DATE

John A. Doe

SIGNATURE OF APPLICANT

FOR OMSIP USE ONLY

ADDITIONAL DEPENDANT CHILDREN (FIRST GIVEN NAME ONLY)	BIRTH DATE DAY MONTH YEAR	SEX M or F
5TH CHILD		
6TH CHILD		
7TH CHILD		
8TH CHILD		
9TH CHILD		

FOR ADDITIONAL CHILDREN ATTACH A SEPARATE SHEET

17

PREMIUM ASSISTANCE

I HEREBY APPLY FOR PREMIUM ASSISTANCE. I DECLARE
THAT I HAVE LIVED IN ONTARIO FOR THE PAST 12 MONTHS.
I AM NOT COVERED FOR TOTAL MEDICAL CARE BY GOVERNMENT.
THE TAXABLE INCOME OF MYSELF AND OF MY ELIGIBLE DEPEND-
ANTS WAS IN TOTAL \$ FOR THE YEAR
ENDING 31 DECEMBER LAST. I AGREE TO ALLOW THE MEDICAL
SERVICES INSURANCE DIVISION TO VERIFY ALL STATEMENTS
MADE BY ME ON THIS APPLICATION.

DATE

19

SIGNATURE OF APPLICANT

REVERSE SIDE OF SAMPLE APPLICATION FORM

16 **Signature.** In the space provided place the date
(number of the day, the month and the year), on
which you are making application for OMSIP
coverage, and sign your name.

17 **Premium Assistance.** Premium assistance is
available on a yearly basis provided you have
lived in Ontario for at least 12 months prior to
the date of application and are not already
covered for total medical care by government.
Premium assistance is based on the combined
total taxable income of you and your dependants
for the year ended December 31st last.

Note: Taxable income is the amount of in-
come on which you pay tax AFTER deductions
for dependants (wife, children) and other exemp-
tions (medical expenses, charitable donations,
etc.)

If you and your dependants had no taxable in-
come for the year ended December 31st last,
write "NIL" in the space provided. You will then
receive OMSIP coverage free of charge.

Sign your name on the line marked "Signature of
Applicant" and write in the date (day, month and
year).

**MAKE SURE YOUR APPLICATION IS
FILLED OUT ACCURATELY**

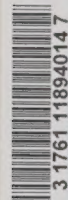
Information given on your application form will
be recorded in OMSIP's computer data file.

Note: All OMSIP claims for medical services
are computer processed. Information given on
your claim is matched by OMSIP's computer
with the information originally provided on your
application. Your claim can be paid only when
the information on your claim matches the in-
formation on our file.

IMPORTANT: OMSIP coverage commences
three months following the date
on which your application is
received and approved. See
OMSIP General Information
Brochure No. E-205D for full
details and exceptions.

DO NOT SEND PAYMENT WITH APPLICATION FORM

CA 20N
H
-2260



OMSIP

APPLICATION INSTRUCTIONS



ONTARIO MEDICAL SERVICES INSURANCE PLAN
135 ST. CLAIR AVENUE W., TORONTO
PHONE 365-5911 • 365-5951



ONTARIO MEDICAL SERVICES INSURANCE PLAN